



## Express Pharmacy Services

### About Express Pharmacy Services

EPS is one of the oldest and largest mail service pharmacies in the country. Founded in 1983, EPS is a service of Eckerd Health Services which is a member of the JCPenney family.

EPS guarantees that all prescriptions will meet the highest pharmacy standards of quality, safety and effectiveness. Each and every prescription is filled and checked by highly qualified registered pharmacists to ensure the quantity, quality and potency are accurate. A patient profile is maintained on file to ensure there are no adverse reactions with other prescriptions you are receiving from Express Pharmacy Services. Our pharmacist will contact your doctor or you before dispensing medication if any questions arise regarding potential drug interactions or other adverse reactions.

### Who is eligible for benefits?

If you and your family are presently covered for outpatient prescription drugs under your employer's medical plan, you are eligible to enroll in the home delivery program.

### What is covered?

The program covers any drug which by federal law requires a doctor's prescription and is covered by your employer's prescription benefit plan.

### What is not covered?

This program does not cover any medicine that can be purchased over the counter. Please refer to your Benefit Plan Summary for specifics on any other drug exclusions.

### What are the advantages of using Express Pharmacy Services?

With Express Pharmacy Services, you can save both time and money because you can receive up to a 90-day supply (or the maximum days supply allowed by your prescription plan) per copayment. Otherwise, through a retail pharmacy, you are limited to a 30-day maximum supply and required to pay the copayment for each prescription.

Plus, by taking advantage of mail order service, you eliminate frequent trips to the retail pharmacy.

### How do I pay for the prescriptions?

**EPS accepts checks, money orders and any of the following credit cards:**

- JCPenney
- Discover
- MasterCard
- American Express
- VISA

If you do not have a credit card, you may call 1-800-222-3383 to request a JCPenney credit card application.

### How do I use the program the first time?

1. When your doctor prescribes a maintenance drug, have the prescription written for up to a 90-day supply (or the maximum days supply specified by your prescription plan). By law, Express Pharmacy Services can only fill your prescriptions for the quantity indicated by your doctor. Example:
  - 1 a day = 90 pills • 2 a day = 180 pills
2. Complete the Enrollment Order Form and Confidential Patient Profile for you and your covered family members. **This form will need to be completed with your first order only.** In the future, if you have additional medical information or changes to report, please notify Express Pharmacy Services in writing.
3. Mail this completed form along with the original prescription and copayment to Express Pharmacy Services, P.O. Box 9062, Clearwater, FL 33758-9748.
4. Be sure to write the member number on the back of each prescription.
5. Drugs will be delivered postage-paid directly to your home. If you have any questions or problems concerning your prescription order, or if you do not receive your medication in 14 days, please contact Express Pharmacy Services toll-free at 1-800-222-3383. Allow a few extra days the first time you place an order with Express Pharmacy Services.

#### EHS CUSTOMER SERVICE HOURS:

24 hours a day Monday through Friday  
9:00 a.m. to 8:00 p.m. Saturday  
9:00 a.m. to 6:00 p.m. Sunday  
(Eastern Times)

**1-800-222-3383**

TDD-Hearing Impaired:

**1-800-238-0756**

### When Should I Use Express Pharmacy Services' (EPS) Prescription Drug Program?

The EPS mail service program is designed mainly for individuals using maintenance-type medications for 30 days or longer to treat chronic or long-term conditions. These conditions include, but are not limited to, diabetes, arthritis, heart conditions and high blood pressure.

### How do I order refills or new prescriptions?

- For **refills**, complete the Prescription Order Form provided with your order and **mail** or **FAX** it to Express Pharmacy Services. You may also **call** EPS at 1-800-222-3383 and provide the member number, prescription number(s) and credit card information. The prescription label and the Customer receipt will indicate the number of times you may have a prescription refilled.
- You can visit the member area of our website at **www.ehs.com**.
- For **new prescriptions**, simply complete the Prescription Order Form included with each order and **mail** both the form and original prescription(s) to EPS. Be sure to write the member number on the back of each prescription.

### What about Generic Drugs?

The generic name of a drug is simply its chemical name. Generic drugs meet strict FDA requirements and are as safe, efficient and effective as brand-name drugs, but considerably less expensive. Generic substitutes will be dispensed by the pharmacist whenever possible, based upon availability, legal requirements, and your physician's approval.

### Before leaving your doctor's office remember to:

- Discuss the possibility of using a generic medication.
- Examine the prescription to make sure it includes the dosage, your doctor's signature and your name and address.
- Have your doctor write your prescription for up to a 90-day supply (or the maximum days supply allowed by your prescription plan). If you need medication immediately, ask your doctor to issue two prescriptions – one for an immediate supply to be taken to your local pharmacy, and a second for an extended supply, to be mailed to Express Pharmacy Services.
- Please note, EPS requires a prescription for insulin and insulin syringes. If you need to order insulin or insulin syringes ask your doctor to write a prescription for each.

Insurance Plan

Member Name

Employer Name

Member Number (Social Security Number)

Member Address:

Street

City

State

Zip

( )

( )

Daytime Phone

Home Phone

E-mail Address

By providing your e-mail address you are granting Express Pharmacy Services permission to contact you via e-mail regarding your prescription orders and prescription drug coverage.

CONFIDENTIAL PATIENT PROFILE

Member

Last Name

First

MI

Date of Birth

/

/

Sex

ALLERGIES (check boxes)

☐ None

☐ 1 Penicillin

☐ 2 Chocolate

☐ 3 Sulfa

☐ 4 Aspirin

HEALTH CONDITIONS (check boxes)

☐ 5 Thyroid

☐ 6 Diabetes\*

☐ 7 Glaucoma

☐ 8 Heart Condition

☐ 9 High Blood Pressure

Other health conditions/allergies

\*Indicate the type of supplies being used -

Monitor

Lancets

Test Strips

Spouse

Last Name

First

MI

Date of Birth

/

/

Sex

ALLERGIES (check boxes)

☐ None

☐ 1 Penicillin

☐ 2 Chocolate

☐ 3 Sulfa

☐ 4 Aspirin

HEALTH CONDITIONS (check boxes)

☐ 5 Thyroid

☐ 6 Diabetes\*

☐ 7 Glaucoma

☐ 8 Heart Condition

☐ 9 High Blood Pressure

Other health conditions/allergies

\*Indicate the type of supplies being used -

Monitor

Lancets

Test Strips

Dependent

Last Name

First

MI

Date of Birth

/

/

Sex

ALLERGIES (check boxes)

☐ None

☐ 1 Penicillin

☐ 2 Chocolate

☐ 3 Sulfa

☐ 4 Aspirin

HEALTH CONDITIONS (check boxes)

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Other health conditions/allergies

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Test Strips

**PLEASE READ AND SIGN:** I certify that the information provided on this form is correct and authorize the release of all information to the plan sponsor, administrator or underwriter; and I AUTHORIZE EXPRESS PHARMACY SERVICES TO SUBSTITUTE GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE, IN ACCORDANCE WITH APPLICABLE LAW, CONSISTENT WITH MY DOCTOR'S ORDERS.

## PRESCRIPTION ORDER FORM FOR NEW PARTICIPANTS

Prescriptions are for: ☐ Member ☐ Spouse ☐ Dependent

Please write the member number on the back of each prescription.

Childproof caps are used for safety in shipping. ☐ **Check here if you want non-childproof caps with this order.**

### Brand-Name Prescriptions

Quantity: \_\_\_\_\_

Copay: \$ \_\_\_\_\_

Total: \$ \_\_\_\_\_

### Generic Prescriptions

Quantity: \_\_\_\_\_

Copay: \$ \_\_\_\_\_

Total: \$ \_\_\_\_\_

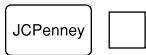
Payment is being made by: ☐ Check ☐ Money Order ☐ Credit Card

Please make check or money order payable to:

Express Pharmacy Services.

**Do not send cash.**

If paying by credit card, indicate the credit card you wish to use and provide the account number and the expiration date:



Credit Card Account Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

☐ Check here if you do not want future orders charged to your credit card on file.